Insurance Services

Field Underwriting

Medical Questionnaires can be found at our website

Producer Information

Name: ______________________ Date Needed: ______________

Email (for response): ______________________ Phone Number: ______________

Client Information

Name: ______________ State: _______ DOB: ________ Gender: ☐ M ☐ F

Height: ___'___" Weight: ____ lbs Weight loss in last 12 mos? ☐ Y ☐ N Amount ___ lbs

Policy Design

Face Amount: $ ______________________ ☐ Term ☐ Permanent

Medical Information

Have you ever used any kind of tobacco or marijuana products? ☐ Yes ☐ No

☐ Marijuana ☐ Cigarette ☐ Pipe ☐ Cigar ☐ Chew ☐ Gum/Patch ☐ Vape

Frequency: Amount ________ ☐ Daily ☐ Weekly ☐ Monthly Date Last Used: __________

Do you have a history of the following?

Additional medical questionnaire required for each checked impairment below. They can be found at our website

☐ **None**	☐ Diabetes
☐ Alcohol Abuse	☐ Drug Abuse
☐ Alzheimer's/Dementia/Cognitive Impairment	☐ Epilepsy
☐ Arthritis	☐ Hepatitis
☐ Asthma	☐ Irregular Heartbeat/Palpitations/ Afib
☐ Auto-Immune Disease	☐ Kidney Disease
☐ Bypass/Stents	☐ Mental Disorders
☐ Cancer	☐ Multiple Sclerosis
☐ Cirrhosis	☐ Peripheral Vascular Disease
☐ COPD	☐ Sleep Apnea
☐ Coronary Artery Disease/Heart Attack	☐ Stroke/TIA
☐ Crohn's / Ulcerative Colitis	☐ Thyroid Disease
☐ Depression/Anxiety	☐ Other

Please list any other medication(s) or medical condition(s): (provide doses and frequency of medications)

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Activity Information

Do you participate in any hazardous activities? ☐ Yes ☐ No

☐ Flying ☐ Scuba ☐ Climbing ☐ Diving ☐ Other

Details: ____

Do you have any plans for foreign travel? ☐ Yes ☐ No

Details: ____

Family Medical History

Family Member	Age if deceased, age @ death and cause	History of Heart Disease?		History of Cancer?	
Mother		☐ Yes	☐ No	☐ Yes	☐ No
Father		☐ Yes	☐ No	☐ Yes	☐ No
Sibling 1		☐ Yes	☐ No	☐ Yes	☐ No
Sibling 2		☐ Yes	☐ No	☐ Yes	☐ No

Driving Record

Have you had any of the following?

☐ Ticket(s): Date: __________ Reason: ________________________ How much over speed limit _____mph

☐ License Suspended/Revoked: Date: ________ Reason: ____

☐ DUI(s): Date: __________ Punishment: _________________________________ Currently drink? ☐ Yes ☐ No

Criminal and Legal History

Crime charged with? _______________________________________ Date: ________________

Punishment: ____ ☐ Felony or ☐ Misdemeanor

Currently on probation? ☐ Yes ☐ No Date probation ended __________________

Financial History

☐ Bankruptcy Chapter ________ Discharged? ☐ Yes ☐ No Payment plan details ___________________

☐ Tax Lien ☐ Collections

Date: ________ Reason: ____

Additional Notes

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